		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027342

Facility Name: CANTERBURY MANOR NURSING CENTER

Address: 718 N. MARKET (Number) WATERLOO (City) 62298 (Zip Code)

County: MONROE

Telephone Number: (618)939-3650 **Fax #** (618)939-9488

IDPA ID Number: 371119687001

Date of Initial License for Current Owners: 03/01/70

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MANAGEMENT CORP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) Controller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,101	89	605	1,795	8
9	SNF/PED					9
10	ICF	11,962	10,091		22,053	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,063	10,180	605	23,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.29%

D. How many bed-hold days during this year were paid by Public Aid? 31 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 605

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTI # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	115,519	6,663	5,926	128,108		128,108		128,108			1
2	Food Purchase		74,613		74,613	6,718	81,331	(329)	81,002			2
3	Housekeeping	64,320	11,266		75,586	(120)	75,466		75,466			3
4	Laundry	58,951	6,871		65,822		65,822		65,822			4
5	Heat and Other Utilities			67,488	67,488	469	67,957		67,957			5
6	Maintenance	26,126	12,633	23,660	62,419		62,419		62,419			6
7	Other (specify):*											7
8	**TOTAL General Services**	264,916	112,046	97,074	474,036	7,067	481,103	(329)	480,774			8
	B. Health Care and Programs											
9	Medical Director			250	250		250		250			9
10	Nursing and Medical Records	853,904	26,103	101,876	981,883	(5,328)	976,555		976,555			10
10a	Therapy	20,237		3,800	24,037		24,037		24,037			10a
11	Activities	39,728	6,331	2,160	48,219	(3,125)	45,094		45,094			11
12	Social Services	31,450		2,160	33,610		33,610		33,610			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	945,319	32,434	110,246	1,087,999	(8,453)	1,079,546		1,079,546			16
	C. General Administration											
17	Administrative	53,745			53,745	66,010	119,755		119,755			17
18	Directors Fees											18
19	Professional Services			197,192	197,192	(115,421)	81,771	(74,862)	6,909			19
20	Dues, Fees, Subscriptions & Promotions			7,649	7,649	260	7,909	(3,773)	4,136			20
21	Clerical & General Office Expenses	24,002	7,091	5,390	36,483	24,087	60,570	(375)	60,195			21
22	Employee Benefits & Payroll Taxes			181,322	181,322	13,945	195,267		195,267			22
23	Inservice Training & Education			256	256		256		256			23
24	Travel and Seminar			3,868	3,868	297	4,165		4,165			24
25	Other Admin. Staff Transportation					1,783	1,783		1,783			25
26	Insurance-Prop.Liab.Malpractice			34,743	34,743	1,674	36,417		36,417			26
27	Other (specify):*											27
28	**TOTAL General Administration**	77,747	7,091	430,420	515,258	(7,365)	507,893	(79,010)	428,883			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,287,982	151,571	637,740	2,077,293	(8,751)	2,068,542	(79,339)	1,989,203			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER #0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			21,150	21,150	3,004	24,154	41,366	65,520			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,338	5,338		5,338	(1,475)	3,863			32
33	Real Estate Taxes					680	680	20,538	21,218			33
34	Rent-Facility & Grounds			354,000	354,000	5,067	359,067	(354,000)	5,067			34
35	Rent-Equipment & Vehicles			114	114		114		114			35
36	Other (specify):*											36
37	**TOTAL Ownership**			380,602	380,602	8,751	389,353	(293,571)	95,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,254	35,024	63,278		63,278		63,278			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		28,254	75,539	103,793		103,793		103,793			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,287,982	179,825	1,093,881	2,561,688		2,561,688	(372,910)	2,188,778			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,962	30		9
10	Interest and Other Investment Income	(46,115)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(329)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(30)	21		18
19	Entertainment				19
20	Contributions	(345)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,118)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(455)	20		28
29	Other-Attach Schedule	(200)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,630)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(344,280)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (344,280)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (372,910)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CANTERBURY MANOR NURSING CENTER

ID# 0027342

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ELIMINATE ONE YEAR OF TWO YEAR	$		1
2	IDPH LICENSE PAID IN 2003 FOR 2003 AND 2004	(200)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(200)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(329)	0	0	0	0	0	0	0	0	0	0	(329)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(329)	0	0	0	0	0	0	0	0	0	0	(329)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(74,862)	0	0	0	0	0	0	0	0	0	(74,862)	19
20	Fees, Subscriptions & Promotions	(3,773)	0	0	0	0	0	0	0	0	0	0	(3,773)	20
21	Clerical & General Office Expenses	(375)	0	0	0	0	0	0	0	0	0	0	(375)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,148)	(74,862)	0	0	0	0	0	0	0	0	0	(79,010)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,477)	(74,862)	0	0	0	0	0	0	0	0	0	(79,339)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	21,962	19,404	0	0	0	0	0	0	0	0	0	41,366	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46,115)	44,640	0	0	0	0	0	0	0	0	0	(1,475)	32
33	Real Estate Taxes	0	20,538	0	0	0	0	0	0	0	0	0	20,538	33
34	Rent-Facility & Grounds	0	(354,000)	0	0	0	0	0	0	0	0	0	(354,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,153)	(269,418)	0	0	0	0	0	0	0	0	0	(293,571)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,630)	(344,280)	0	0	0	0	0	0	0	0	0	(372,910)	45

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		SENIOR MANOR NURSING CENTER	SPARTA	Jamestown Mgmt	Carbondale	Management
		FAIR ACRES NURSING HOME	DUQUOIN	Corp		
		FAIRVIEW NURSING CENTER	DUQUOIN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 190,600	JAMESTOWN MANAGEMENT CORPORATION	10.00%	$ 115,738	$ (74,862)	1
2	V	33	REAL ESTATE TAXES		WATERLOO LAND TRUST	100.00%	20,538	20,538	2
3	V	34	RENT	354,000	WATERLOO LAND TRUST	100.00%		(354,000)	3
4	V	32	INTEREST EXPENSE		WATERLOO LAND TRUST	100.00%	45,775	45,775	4
5	V	30	DEPRECIATION		WATERLOO LAND TRUST	100.00%	19,404	19,404	5
6	V	32	INTEREST INCOME		WATERLOO LAND TRUST	100.00%	(1,135)	(1,135)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 544,600			$ 200,320	$ * (344,280)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENT # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO THE COST REPORT								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Jamestown Management Corp
Street Address: 1001 E. Main Bldg 4a
City / State / Zip Code: Carbondale, IL 62901
Phone Number: (618) 549-8331
Fax Number: (618) 549-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158		$ 5,822	$	3,485	$ 1,117	1
2	5	UTILITES	HOURS OF SERVICE	18,158		2,445		3,485	469	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	11,484		343,946	343,946	2,204	66,010	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	18,158		1,652		3,485	317	4
5	20	LICENSES & DUES	HOURS OF SERVICE	18,158		1,355		3,485	260	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	6,674		110,867	110,867	1,281	21,280	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	18,158		9,170		3,485	1,760	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	18,158		62,630		3,485	12,020	8
9	24	SEMINARS	HOURS OF SERVICE	11,484		1,546		2,204	297	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	11,484		9,288		2,204	1,783	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		8,724		3,485	1,674	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		15,654		3,485	3,004	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158		3,545		3,485	680	13
14	34	RENT	HOURS OF SERVICE	18,158		26,400		3,485	5,067	14
15										15
16										16
17										17
18			**EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN							18
19			ELIMINATED PRIOR TO COST REPORT.							19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 603,044	$ 454,813		$ 115,738	25

Facility Name & ID Number CANTERBURY MANOR NURSING CENTI # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Canterbury Manor Nursing	x		1st mortgage	$4,741.00	07/20/00	$ 565,000	$ 502,507	07/20/25	0.0900	$ 45,775	1
2	Center											2
3												3
4												4
5												5
	Working Capital											
6	Waterloo Land Trust	x		Operating Funds		07/31/03	5,000	5,000	demand	0.0600		6
7												7
8												8
9	TOTAL Facility Related				$4,741.00		$ 570,000	$ 507,507			$ 45,775	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 570,000	$ 507,507			$ 45,775	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	20,538	2
3. Under or (over) accrual (line 2 minus line 1).	$	20,538	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	20,538	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	13,968	8
1999	15,009	9
2000	18,418	10
2001	20,341	11
2002	20,538	12

***Line 7 does not include the Jamestown allocation from page 8 sch VIII of $680. Real estate taxes of page 4 line 33 should reconcile to line 7 $20538 + Jamestown $680= $21218.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CANTERBURY MANOR NURSING CENTER COUNTY MONROE

FACILITY IDPH LICENSE NUMBER 0027342

CONTACT PERSON REGARDING THIS REPORT Roger W. Bagley

TELEPHONE (618) 549-8331 FAX #: (618)549-0133

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-24-250-031-000	N. Market Street part lot 1 sur 640	$ 1,685.00	$ 1,685.00
2.	07-24-250-026-000	718 N. Market Street Tax Lot 6 BA	$ 18,853.00	$ 18,853.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 20,538.00	$ 20,538.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,374 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	original bldg & addition	50,000	1970-75	$ 25,823	1
2	additional land	22,597	1995	108,977	2
3	TOTALS	72,597		$ 134,800	3

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1970	1970	$ 123,000	$	30	$	$	$ 123,000	4
5	14		1976	1976	80,226		25			80,226	5
6			1970	1970	49,513		25			49,513	6
7			1976	1976	866		10			866	7
8			1976	1976	10,413		15			10,413	8
	Improvement Type**										
9	VARIOUS/FULLY DEPRECIATED			1970	14,327		various			14,327	9
10	REMODELING			1974	565		25			565	10
11	NURSES CALL SYSTEM			1976	7,457		15			7,457	11
12	NURSES STATION			1976	30,851		20			30,851	12
13	SPRINKLER & SMOKE DETECTOR			1976	34,295		25			34,295	13
14	REMODELING			1977	6,714		15-20			6,714	14
15	LAND IMPROVEMENTS			1980	900		15			900	15
16	LAND & GUTTERING			1981	7,199		15			7,199	16
17	ROOF REPAIR & ACTIVITY ROOM			1986	30,422		15			30,422	17
18	PARKING LOT			1987	1,670		7			1,670	18
19	GAS LINE			1989	1,637	109	15	109		1,581	19
20	VARIOUS IMPROVEMENTS			1990	13,962	931	15	931		12,568	20
21	CABINETS & FLOORING			1994	2,461	164	15	164		1,559	21
22	VARIOUS IMPROVEMENTS			1994	21,632	1,442	15	1,442		13,699	22
23	ROOF REPAIR			1995	2,565	171	15	171		1,454	23
24	WATER HEATER			1995	3,000		15	200	200	1,700	24
25	FIRE ALARM			1995	7,207		15	480	480	4,080	25
26	TELEPHONE SYSTEM			1995	713		20	36	36	306	26
27	CARPETING			1996	2,423		7	174	174	2,423	27
28	RENOVATING ROOMS			1996	4,403	440	10	440		3,300	28
29	REPLACED WATER HEATER			1996	550		15	37	37	277	29
30	REPAIR SHOWER			1996	2,244	224	10	224		1,680	30
31	LANDSCAPING			1996	973	97	10	97		728	31
32	REPLACE WATER HEATER			1996	680		15	45	45	338	32
33	Labor/materials to remove existing and install new waterproof			1997	4,009	401	10	401		2,606	33
34	wallcovering and floor tile										34
35	Labor/materials to remove and install new cabinets/countertops			1997	6,853	685	10	685		4,453	35
36	in nurses station										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REPAIR PLUMBING	1997	$ 4,010	$ 267	15	$ 267	$	$ 1,736	37
38	REPAIR GROUNDWATER DRAIN	1997	790	53	15	53		344	38
39	PREP AND SEAL PARKING LOT	1997	1,145		5			1,145	39
40	SIGN	1997	531		5			531	40
41	OVERBED LIGHTING	1998	8,636	864	15	576	(288)	3,168	41
42	FLOORTILE AND CARPETING	1998	10,612	1,516	15	707	(809)	3,889	42
43	LANDSCAPING	1998	4,817	482	10	482		2,651	43
44	Labor/materials to remove entry way, rebuild walls, paint	1998	11,907	1,191	15	794	(397)	4,367	44
45	& replace elec serv in DON, Socserv, breakroom. Move wall								45
46	to expand kitchen. Created storage area by relocating doors								46
47	Trims, pictures, mirrors, & other permanent fixtures to	1998	3,025	49	5	302	253	3,025	47
48	refurbish the remodeled building.								48
49	PARKING LOT	1998	56,963		15	3,798	3,798	20,889	49
50	WATER SOFTNER	1998	1,400		10	140	140	770	50
51	FIRE SUPRESSION SYSTEM	1998	1,356		10	136	136	748	51
52	GAZEBO	1999	4,084		20	204	204	918	52
53	COURTYARD AWNINGS	1999	850		5	170	170	765	53
54	INSTALL 911 ALARM SYSTEM	1999	519	104	5	104		468	54
55	LANDSCAPING AND SIDEWALKS	1999	2,189	219	10	219		985	55
56	WINDOWS FOR FRONT OF BUILDING	1999	2,658	266	10	266		1,197	56
57	LANDSCAPING OF COURTYARD	1999	466	47	10	47		211	57
58	WALLPAPERING	1999	218	44	5	44		198	58
59	BUILDING ADDITION	2000	411,559		15	27,437	27,437	96,030	59
60	ADJUSTMENT TO 1999 DPA COST REPORT	2000	(173)						60
61	BUILDING ADDITION	2000	17,651		15	1,177	1,177	4,119	61
62	DOOR ALARM SYSTEM	2000	5,996		10	600	600	2,100	62
63	Labor/materials to install new cabinets/countertops, relocate	2000	1,346		10	135	135	472	63
64	heating, electrical services, and lighting in the breakroom								64
65	EXTENSION & MODEM JACK INSTALLED IN NEW OFFICE	2000	1,071		10	107	107	375	65
66	Labor/materials to remove existing wall and relocate wall	2000	9,093	1,048	10	909	(139)	3,182	66
67	to expand nurses station and install new cabinetry &								67
68	countertops, lighting, and electrical services.								68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,036,449	$ 10,814		$ 44,310	$ 33,496	$ 605,453	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,036,449	$ 10,814		$ 44,310	$ 33,496	$ 605,453	1
2	INSTALL TILE FLOORING IN EAST WING	2000	6,858	790	15	457	(333)	1,600	2
3	CABINETS INSTALLED IN 6 MED ROOMS	2000	5,789	667	15	386	(281)	1,351	3
4	Labor and materials to remove existing cabinetry and sinks	2000	2,845	328	15	190	(138)	665	4
5	and install new cabinets/sinks, replace plumbing and								5
6	electrical on east wing								6
7	ABSTRACT WATER FOUNTAIN IN COURTYARD	2000	1,155	144	5	231	87	809	7
8	FRUIT URN FOUNTAIN IN DRIVE	2000	945	118	5	189	71	662	8
9	LANDSCAPING	2000	1,519	175	10	152	(23)	532	9
10	ELEVATED EAST WING FLOOR/WALLS OF BUILDING	2001	3,875	258	15	258		645	10
11	Replaced employee door, new frame, door, and hardware	2001	2,129	213	10	213		532	11
12	Code modifications to fire sprinkler system	2001	2,566	257	10	257		642	12
13	Installation & replacement of aluminum patio door system	2001	4,223	422	10	422		1,055	13
14	Replace pressure switch and repair lines in fire sprinkler sys	2002	5,790	579	10	579		869	14
15	SEAL AND STRIPE PARKING LOT	2002	3,440	688	5	688		1,032	15
16	Relocate 2 water meters to meet city codes	2002	1,700	113	15	113		170	16
17	REPLACED WATER HEATER	2003	3,539	506	10	177	(329)	177	17
18	REPLACED WATER SOFTNER	2003	1,913	273	10	96	(177)	96	18
19	INSTALLED WIRING FOR CABLE TV INSTALLATION	2003	2,898	580	10	145	(435)	145	19
20	Demolition and reconstruction of wall, relocate door, and	2003	6,155	308	10	308		308	20
21	install electrical service for laundry.								21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,093,788	$ 17,233		$ 49,171	$ 31,938	$ 616,743	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 116,177	$ 3,105	$ 12,933	$ 9,828	variable	$ 74,989	71
72	Current Year Purchases	5,683	812	412	(400)	variable	412	72
73	Fully Depreciated Assets	152,052				variable	152,052	73
74								74
75	TOTALS	$ 273,912	$ 3,917	$ 13,345	$ 9,428		$ 227,453	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			$	$ 3,004	$ 3,004	$		$ 21,253	76
77										77
78										78
79										79
80	TOTALS			$	$ 3,004	$ 3,004	$		$ 21,253	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,502,500	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,154	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,520	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 41,366	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 865,449	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 114 Description: storage 114
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   We only hire trained aides.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3;39/2	hrs	$	166	$ 12,078	$ 203	166	$ 12,281	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		27	2,238		27	2,238	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		240	16,673		240	16,673	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				21,178		21,178	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	oxygen, tubefeeding, medical supplies Other (specify): lab, xray, ambulance	39/2 39/3				4,035	6,873		10,908	13
14	TOTAL			$	433	$ 35,024	$ 28,254	433	$ 63,278	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,847	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	210,807		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	15,110		5
6	Prepaid Insurance	1,279		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): income tax deposits	4,400		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 290,443	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	219,954		15
16	Equipment, at Historical Cost	207,274		16
17	Accumulated Depreciation (book methods)	(333,193)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan to Waterloo Land Trust	497,507		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 591,542	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 881,985	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 30,441	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,005		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,084		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401k Liability	11,654		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 89,184	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 89,184	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 792,801	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 881,985	$	48

***(See instructions.)**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 957,253	1
2	Restatements (describe):		2
3	**Federal Tax Refund Received**	8,736	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 965,989	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(173,188)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (173,188)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 792,801	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,235,687	1
2	Discounts and Allowances for all Levels	34,782	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,270,469	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,820	6
7	Oxygen	3,132	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,952	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,330	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,330	23
	D. Non-Operating Revenue		
24	Contributions	13,634	24
25	Interest and Other Investment Income***	46,115	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,749	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,388,500	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	474,036	31
32	Health Care	1,087,999	32
33	General Administration	515,258	33
	B. Capital Expense		
34	Ownership	380,602	34
	C. Ancillary Expense		
35	Special Cost Centers	63,278	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,561,688	40
41	**Income before Income Taxes (line 30 minus line 40)****	(173,188)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (173,188)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **IL taxes are deducte on federal tax retur**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,888	2,080	$ 45,706	$ 21.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,716	2,798	57,258	20.46	3
4	Licensed Practical Nurses	14,264	15,518	258,158	16.64	4
5	Nurse Aides & Orderlies	44,713	47,430	484,095	10.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,453	1,579	20,237	12.82	8
9	Activity Director	3,443	3,707	39,728	10.72	9
10	Activity Assistants					10
11	Social Service Workers	1,830	2,095	31,450	15.01	11
12	Dietician					12
13	Food Service Supervisor	1,822	2,118	29,942	14.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,729	10,238	85,577	8.36	15
16	Dishwashers					16
17	Maintenance Workers	2,022	2,282	26,126	11.45	17
18	Housekeepers	7,536	7,965	64,320	8.08	18
19	Laundry	6,233	6,712	58,951	8.78	19
20	Administrator	1,944	2,080	53,745	25.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,101	2,193	24,002	10.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) ward clerk	1,012	1,089	8,687	7.98	33
34	TOTAL (lines 1 - 33)	102,706	109,884	$ 1,287,982 *	$ 11.72	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	127	$ 5,926	1/3	35
36	Medical Director		250	9/3	36
37	Medical Records Consultant		1,068	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	10/3	39
40	Physical Therapy Consultant	50	3,029	10A/3	40
41	Occupational Therapy Consultant	11	712	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	59	10A/3	43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT		519		47
48					48
49	TOTAL (lines 35 - 48)	273	$ 16,483		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 238	L10/C3	50
51	Licensed Practical Nurses	1,194	37,459	L10/C3	51
52	Nurse Aides	3,292	62,511	L10/C3	52
53	TOTAL (lines 50 - 52)	4,494	$ 100,208		53

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHNNY LAW	ADMINSTRATOR	0	$ 53,745
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 53,745

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT CORP	MANAGEMENT	$ 190,600
MIKRON	COMPUTER	1,440
ADP	PAYROLL	576
BARNETT & LEVINE	ACCOUNTING	1,600
M.E.S.	PURCHASING	519
BENEFIT PLANNING CONS	401 k SERVICES	1,288
RAU & RAU	LEGAL	1,169
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 197,192

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,428
Unemployment Compensation Insurance	7,473
FICA Taxes	98,531
Employee Health Insurance	8,763
Employee Meals	1,925
Illinois Municipal Retirement Fund (IMRF)*	
401K EMPLOYER MATCHING FUNDS	11,654
LIFE INSURANCE	96
AWARDS, ATTENDANCE, PARTIES, ETC	10,173
VACCINES	204
JAMESTOWN ALLOCATION	12,020
TOTAL (agree to Schedule V, line 22, col.8)	$ 195,267

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	505
Health Care Worker Background Check	480
(Indicate # of checks performed 40)	
INHAA 100; subscriptions 201	301
ELIMINATE ONE YEAR OF IDPA LICEN	(200)
CORP FEES	390
NAGNA	2,000
OTHER ADVERTISING	3,573
JAMESTOWN ALLOCATION	260
Less: Public Relations Expense	(3,118)
Non-allowable advertising	( )
Yellow page advertising	(455)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	845
Seminar Expense	3,023
JAMESTOWN ALLOCATION	297
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,165

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **40,515**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,925** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

CANTERBURY MANOR NURSING CENTER #0023742
RECLASSIFICATIONS ON DPA COST REPORT
PAGES 3 & 4 COLUMN 5
12/31/2003

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	5518	
10	NURSING & MEDICAL RECORDS		5518
	RECLASSIFY FOOD SUPPLEMENTS		
21	CLERICAL & GEN OFFICE EXPENSE	1047	
10	NURSING & MEDICAL RECORDS		1047
	RECLASSIFY OFFICE SUPPLIES		
10	NURSING & MEDICAL RECORDS	1237	
3	HOUSEKEEPING		1237
	RECLASSIFY SOAP & SHAMPOO		
2	FOOD PURCHASES	3125	
11	ACTIVITIES		3125
	RECLASSIFY FOOD USED IN ACTIVITIES		
22	EMPLOYEE BENEFITS	1925	
2	FOOD PURCHASES		1925
	RECLASSIFY EMPLOYEE MEALS		
VARIOUS	VARIOUS LINE ITEMS		
19	PROFESSIONAL SERVICES	115738	
	RECLASSIFY JAMESTOWN ALLOCATION		115738
	SEE SCHEDULE VIII FOR BREAKDOWN		